Internal Medicine & Pediatric Associates
6919 Old Canton Road
Ridgeland, MS 39157
Phone: (601) 956-0911
Fax: 601) 952-0474

Date:_______________

PATIENT INFORMATION SHEET

LAST NAME ________________________________ FIRST____________________________ MI _____

ADDRESS____ APT_________

CITY ____ STATE_________ ZIP_________________

HOME PHONE (________) ______________________ CELL PHONE (_______) ____________________

PATIENT'S DATE OF BIRTH _________/_________/___________ PATIENT'S SEX _______M _______F

MARITAL STATUS ____SINGLE ____MARRIED ____DIVORCED ____WIDOWED ____SEPARATED ____PARTNERED

PATIENT'S SOCIAL SECURITY NUMBER ______________-__________-______________

RESPONSIBLE PARTY IS AUTOMATICALLY THE PATIENT UNLESS THE PATIENT IS A MINOR.

IF MINOR, PARENTS INFORMATION

FATHER'S NAME____ DOB _______/______/_______

EMPLOYER ____ PHONE ___________________

CELL PHONE (_______)___________________________ SOCIAL SECURITY ________-______-__________

MOTHER'S NAME____ DOB _______/______/_______

EMPLOYER ____ PHONE ___________________

CELL PHONE (_______)___________________________ SOCIAL SECURITY ________-______-__________

EMPLOYER INFORMATION

EMPLOYER NAME____

ADDRESS ____

CITY_________________________________ STATE__________________ ZIP____________________

EMPLOYER PHONE (___________) _______________________________ EXT______________

EMPLOYMENT STATUS _______F/T ______P/T _____NA STUDENT STATUS _____F/T _____P/T

EMERGENCY CONTACT

NAME____RELATIONSHIP________________

ADDRESS ____

CITY_______________________________________ STATE_________________ ZIP____________________

HOME PHONE ____________________________________ WORK PHONE ______________________________

MESSAGES

OK TO LEAVE MESSAGES AT HOME ______YES ______NO

AT WORK ______YES ______NO

If you would like to be contacted through email for clinic events, such as Flu Shot Clinic, Easter Hunt and Fall Festival, please provide us with your email address:____

AUTHORIZATION TO RELEASE INFORMATION TO

If left blank, your medical information will not be released to anyone.

NAME____RELATIONSHIP_________________

HOME PHONE (__________)__________________________ CELL PHONE (________)_____________________

PHARMACY

NAME ____ LOCATION_________________________

PHONE (_________)__________________________________ FAX (_________)___________________________

INSURANCE INFORMATION

PRIMARY INSURANCE ____

POLICY HOLDER NAME _____________________________________ RELATIONSHIP____________________

POLICY HOLDER DOB ______/______/______ POLICY HOLDER SOCIAL SECURITY______-______-________

ID# ____ GROUP # ______________________________

SECONDARY INSURANCE ____

POLICY HOLDER NAME _____________________________________ RELATIONSHIP____________________

POLICY HOLDER DOB ______/______/______ POLICY HOLDER SOCIAL SECURITY______-______-________

ID# ____ GROUP # ______________________________

PRIMARY CARE PHYSICIAN ____

REFERRING PHYSICIAN ____

We sincerely appreciate the opportunity to serve the medical needs of you and your family. Please take a moment and tell us how you heard about us.

_____Friend Name____

_____Relative Name____

_____Physician Name____

___Kid's Directory___Parent & Child Magazine ___Mail Out____Billboard ____Dropped by on my own

AUTHORIZATION FOR TREATMENT AND PAYMENT AGREEMENT

- I authorize the use of this form and information on all my insurances submissions.
- I authorize the release of information to my insurance company.
- I authorize payment to be made directly to Internal and Pediatric Associates, PLLC.
- I authorize Internal Medicine and Pediatric Associates to act as my agent in helping me to obtain payment from my insurance company.
- I understand I am responsible for my bill.
- I understand I am responsible for my co-payment, co-insurance, and deductible at the time services are rendered.
- I authorize Internal Medicine and Pediatric Associates, physicians and staff, to render treatment to myself or child.

Patient Name (please print) ____

Signature of Patient or Guardian ____________________________________

Date ________/________/_________

Internal Medicine and Pediatric Associates
2011 Patient Financial Policy

Patient Name: ____ **Date:** ________________________

You are responsible for the payment of co-payment, co-insurance, deductibles, non-covered services, or any patient responsibility at the time services are rendered. If you are covered by a plan in which we participate as a provider, we will file your insurance claim. In the event that your insurance carrier does not pay the balance we will notify you so that you may contact your insurance carrier or resolve your account. In the event that your coverage has changed, lapsed, or expired on the date services are rendered, all charges will be denied and become the patient's responsibility.

Co-payments, Co-insurance, and Deductibles: Insurance contracts obligate patients to pay their patient portions and providers to collect these amounts. Please be prepared to pay your co-pay, co-insurance, non-covered services, and deductible amounts at the time services are rendered.

Out of Network Plans: Payment is due in full at the time services are rendered. As a courtesy, we will file a claim to your insurance carrier on your behalf or provide you with a claim form for filing.

Self Pay Patients: Payment is due at the time services are rendered.

Secondary Insurance Carriers: We will file secondary claims if we are participating with the insurance carrier network. If we are non-participating, we will provide the patient with a claim form. If your insurance carrier does not process the claim within 45 days of the claim being filed, the balance becomes the patient's responsibility.

Please read and initial each blank.

______ Patient agrees to pay for all portions of services due in full at the time services are provided by our office.

______ Patient must advise the front office personnel of any insurance changes in a timely manner.

______ If account balances are not paid according to terms, the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, the patient agrees to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees.

______ I understand that IMPA accepts cash, Visa, and MasterCard as payment.

______ If payment of charges imposes a financial burden, payment arrangements must be negotiated **prior** to services being rendered. And are at the discretion of the billing department and the physician providing services.

______ I have read the cancellation policy. I understand that a cancellation fee will be charged if I do not cancel or reschedule within 24 hours of the scheduled appointment time unless there is a valid reason for the cancellation. This will be determined at the discretion of the Office Manager.

______ Until my account is settled, I give my consent to receive communications including voice messages regarding my account through various means such as: cell, landline number or email address that I have provided.

Patient/Guarantor Signature: _________________________ **Print Name:** __________________________

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the notice of Privacy Practices and I have been provided an opportunity to review it.

Name____Birthdate________________

Signature____

Date____

Internal Medicine and Pediatric Associates of Ridgeland, PLLC

Adult Health History for NEW Patients

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. Please fill in all pages. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

Main reason for today's visit:

Wellness/Physical □ Illness □ Explain the illness:____
Other concerns □ Explain: ____
Where were you getting your care before?
____

Please ask for a medical records release form, so that we may obtain these records.

REVIEW OF SYMPTOMS: Please mark the box of any persistent symptoms you have had in the past few months. Read through every section and check "no problems" if none of the symptoms apply to you. List other concerns above.

General
___ Unexplained weight loss / gain
___ Unexplained fatigue / weakness
___ Fall asleep during day when sitting
___ Fever, chills
___ No problems

Skin
___ New or change in mole
___ Rash / itching
___ No problems

Breast
___ Breast lump / pain / nipple discharge
___ No problems

Ears/Nose/Throat
___ Nosebleeds, trouble swallowing
___ Frequent sore throat, hoarseness
___ Hearing loss / ringing in ears
___ No problems

Eyes
___ Change in vision / eye pain / redness
___ No problems

Cardiovascular
___ Chest pain / discomfort
___ Palpitations (fast or irregular heartbeat)
___ No problems

Respiratory
___ Cough / wheeze
___ Loud snoring / altered breathing during sleep
___ Short of breath with exertion
___ No problems

Gastrointestinal
___ Heartburn / reflux / indigestion
___ Blood or change in bowel movement
___ Constipation
___ No problems

Genitourinary
___ Leaking urine
___ Blood in urine
___ Nighttime urination or increased frequency
___ Discharge: penis or vagina
___ Concern with sexual function
___ No problems

Musculoskeletal
___ Neck pain
___ Back pain
___ Muscle / joint pain _____________
___ No problems

Endocrine
___ Heat or cold sensitivity
___ No problems

Hematologic/Lymphatic
___ Swollen glands
___ Easy bruising
___ No problems

Neurological
___ Headache
___ Memory loss
___ Fainting
___ Dizziness
___ Numbness / tingling
___ Unsteady gait
___ Frequent falls
___ No problems

Allergic/Immune
___ Hay fever / allergies
___ Frequent infections
___ No problems

Psychiatric
___ Anxiety / stress / irritability
___ Sleep problem
___ Lack of concentration
___ No problems

Women only
___ Pre-menstrual symptoms (bloating cramps, irritability)
___ Problem with menstrual periods
___ Hot flashes / night sweats
___ No problems

I have been diagnosed previously with the following conditions (check all that apply):
___ AIDS/HIV
___ Alcoholism
___ Anemia
___ Anorexia
___ Appendicitis
___ Arthritis
___ Asthma
___ Bleeding Disorders
___ Bronchitis
___ Bulimia
___ Cancer
___ Cataracts
___ Chemical Dependency
___ Diabetes
___ Emphysema
___ Epilepsy
___ Fibromyalgia
___ Glaucoma
___ Goiter
___ Gonorrhea
___ Gout
___ Heart Disease
___ Hepatitis
___ Hernia
___ Herpes
___ High Blood Pressure
___ High Cholesterol
___ Kidney Disease
___ Liver Disease
___ Measles
___ Other______________

IMMUNIZATIONS: Check off any vaccinations you have had and add year, if known.
Tetanus (Td) _______ With Pertussis (Tdap) ________ Varicella (Chicken Pox) shot or illness _______
Pneumovax (pneumonia) ______ Influenza (flu shot) ______ Hepatitis A ______ Hepatitis B ______ MMR ______
Meningitis ______ Zostavax (shingles) ______ HPV ______

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know you wrote there.
□ I take no medications including over the counter medicines, vitamins, or supplements.

List medication, dose(e.g. mg/pill),and how many times per day?
____
____
____
____
____
____
____

Allergies or intolerance to medications (include type of reaction):
____
____
□ NONE

HEALTH MAINTENANCE SCREENING TESTS:
Lipid (cholesterol) Date ____________________________ Abnormal □ No □ Yes
Sigmoidoscopy or Colonoscopy (circle one) Date ________________________ Polyp □ No □ Yes
Women only:
Mammogram Date ____________________________ Abnormal □ No □ Yes
Pap Smear Date ____________________________ Abnormal □ No □ Yes
Bone Density Test Date ___________________ Abnormal □ No □ Yes
Men only:
Prostate Exam Date ________________________ Abnormal □ No □ Yes

Hospitalizations:
Year _________ Surgery/Illness____
Year _________ Surgery/Illness____
Year _________ Surgery/Illness____
Year _________ Surgery/Illness____
Year _________ Surgery/Illness____
Year _________ Surgery/Illness____
Have you ever had a blood transfusion? □ No □ Yes If yes, give dates________________________

PERSONAL MEDICAL HISTORY:
Are you adopted? □ No □ Yes If yes, and you do not know your family history skip this section and continue to **Other Health Issues**.
Is your mother living? □ No □ Yes If yes, is she in good health? □ No □ Yes If no, age and cause of death:____
Is your father living? □ No □ Yes If yes, is he in good health? □ No □ Yes If no, age and cause of death:____

FAMILY HISTORY: Indicate which relative has had the following diseases (parents and siblings are most important). Please indicate maternal or paternal grandparents.

Disease:
Arthritis, Gout:
Asthma, Hay Fever:
Cancer-type:
Chemical Dependency:
Diabetes:
Heart Disease, Stroke:
High Blood Pressure:
High Cholesterol:
Kidney Disease:
Tuberculosis:
Other:

OTHER HEALTH ISSUES:
Tobacco Use
Smoke cigarettes: □ Never □ No, I quit _____months/years ago. I smoked for ______years.
□ Yes, I smoke. Packs/day: _________ # of years: _________
Other tobacco: □ Pipe □ Cigar □ Snuff □ Chew
Alcohol Use
Do you drink alcohol? □ No □ Yes
# of drinks/week: ___________ □ Beer □ Wine □ Liquor
Drug Use
Do you use marijuana or recreational drugs? □ No □ Yes
Have you ever used needles to inject drugs? □ No □ Yes
Sexual Activity
Sexually involved currently: □ No □ Yes
Sexual partner(s) is/are/have been: □ male □ female
Birth control method (circle below all that apply): □ None needed
Condom, pill, diaphragm, vasectomy, other _________________
Exercise
Do you exercise regularly? □ Yes □ No
What kind of exercise? ________________________________
____
How long (minutes)? _____________ How often? ___________

Diet
How would you rate your diet? □ Good □ Fair □ Poor
Would you like advice on your diet? □ No □ Yes
Safety
Do you use seatbelts consistently? □ Yes □ No
Does your home have a working smoke detector? □ Yes □ No
If you have guns in your home, are they locked up?
□ Not applicable □ Yes □ No
Is violence at home a concern for you? □ No □ Yes

SOCIAL HISTORY:
Occupation (or prior occupation): ____
retired/unemployed/leave of absence/disabled (circle one)
Employer: ______________________________ Years of education or highest degree: ____________
Marital status (check one): □ single, □ partner, □ married, □ divorced, □ widowed
Spouse/partner's name: ______________________________________ Number of children: _______
Ages if under 18 years: ____
Who lives at home with you?
____
Have you recently, in the last 12 months, been out of the country? □ Yes □ No If yes,
where:____

WOMEN'S HEALTH HISTORY:
Total number of pregnancies: _______ Number of births: ________
Date (month/day if known) of last menstrual period if you are still menstruating: ____________
Age at beginning of periods (menstruation): _________
Age at end of periods (menopause): _________

Have you completed an Advance Directive for Health Care (ADHC), Living Will, or POLST (Physician Orders for Life Sustaining Therapy)? (Circle above all that apply)□ No, I have not completed any of the before mentioned.

By signing below, I attest that I have answered the questions on this health history form truthfully and to the best of my abilities.

____
Print Patient Name

____ ____________________________
Patient Signature Date

Thank-you for taking the time to fill this extensive health history from out, it will greatly benefit the provider in taking care of you and your health.   Please be aware that if your medical record needs to be forwarded to a specialist that we have referred you to, this health history form will be included in your records that are sent.